

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028715  
3536 STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF ROBERT C. MC CLELLAN MEDICAL CERTIFICATION

USE BLACK INK  
OR  
TYPEWRITER RIBBON

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                           |                                                                                                                                                             |                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Kansas b. COUNTY Johnson                                  |                               |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Kansas City                                                                                                                                                                                                                                                                                                                                                                                                                                       |                           | Length of stay in 1b<br>1 Day                                                                                                                               |                               |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION Research Hospital                                                                                                                                                                                                                                                                                                                                                                                                                       |                           | d. STREET ADDRESS (If outside, give location)<br>6509 Sagamore Road                                                                                         |                               |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>Henry F Toohey                                                                                                                                                                                                                                                                                                                                                                                                                                             |                           | 4. DATE OF DEATH<br>Month Day Year<br>June 22 1963                                                                                                          |                               |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. COLOR OR RACE<br>White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>8-14-1900 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>President                                                                                                                                                                                                                                                                                                                                                                                                               |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Transfer Co.                                                                                                           |                               |
| 13a. FATHER'S NAME<br>Harry Toohey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                           | 13b. MOTHER'S MAIDEN NAME<br>Julia Farrell                                                                                                                  |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                      |                           | 17. INFORMANT<br>Helen Toohey 6509 Sagamore Road.                                                                                                           |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary Thrombosis<br>DUE TO (b) Coronary Arteriosclerosis<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                           | INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs<br>1-2 yrs                                                                                                       |                               |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                      |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)                                                                |                               |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                           | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE                                                                                                                |                               |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                 |                           | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                               |
| 21. I attended the deceased from 5/24/62 to 6/22/63 and last saw her alive on 6/22/63<br>Death occurred at Research Hospital 4:55 PM on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                                                                                                |                           | 22b. ADDRESS<br>22c. DATE SIGNED<br>6/24/63                                                                                                                 |                               |
| 22a. SIGNATURE<br>(Degree or title)<br>Robert C. McClellan M.D. No 3894                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           | 22c. DATE SIGNED<br>(State)                                                                                                                                 |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           | 23b. DATE<br>6-24-63                                                                                                                                        |                               |
| 23c. NAME OF CEMETERY OR CREMATORY<br>D.W. Newcomer's Sons                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                           | 23d. LOCATION (City, town, or county)<br>Kansas City, Missouri                                                                                              |                               |
| 24. FUNERAL DIRECTOR<br>Stine & McClure Kansas City, Missouri                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                           | 25. DATE RECD. BY LOCAL REG.<br>6-24-63                                                                                                                     |                               |
| 26. REGISTRAR'S SIGNATURE<br>Ruth Long                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           |                                                                                                                                                             |                               |

*Post Mortem Examination*

*Feb 1 - 1892*

*Research Room.*

*9:00 Sunday Morn.*

*820 Post Bldg*

*9:00 - 9:30*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Richard L. Powers*

Licensed Embalmer No. *5190*

P. O. Address *San Jose City, Cal.*

- Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.